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COMMUNITY DEVELOPMENT STRATEGY, 1983 - 1987

NORTHERN HEALTH AREA
DEPARTMENT OF PUBLIC HEALTH
CITY OF TORONTO

APRIL 1983

COMMUNITY DEVELOPMENT STRATEGY, 1982 - 1987

1. Theoretical basis for community development

Public health is defined in Public Health in the 1980's as "collective action to protect and enhance the physical and mental health of a community, through preventive rather than curative action". The key words here are "collective.... community....preventive" and it is from these key words and the concepts they embody that our community development strategy is developed.

Our approach to community development and health is based in part upon the work of John McKnight and his colleagues at the Centre for Urban Affairs at Northwestern University, who have developed a health action model (McKnight 1981) based on the notion that there are health consequences to social disorganization (Cassel, 1974). In developing this health action model, they proposed three assumptions, namely:

(1) certain health indices may be related to the degree of social organization among a population. Therefore the strength of a community's capacity to organize and alleviate certain health problems is health promoting in itself.

(ii) Intervention for the control of ill-health ideally should be at the causative level rather than at the time of medical detection or treatment.

(iii) Community based strategies designed in accordance with the first two propositions will not only improve community health but strengthen community organization as well.

Indeed, according to the health action model, the goal of health action is an enhanced, strengthened and more organized community, from which one benefit may be improved health. Thus community development is to be viewed as a means of empowering the community to act for itself, both in health-related and non health-related issues.

Empowerment is a crucial concept in community development. Berger and Neuhaus (1977) suggest that we face a dilemna in the field of human services - people want more welfare state services, yet at the same time they want less government. This is because the government has become a megastructure that is devoid of personal meaning and that is no longer viewed as benign. We are then faced with the need "to address human needs without exacerbating the reasons for animus against the welfare state." (p. 2) The goal of public policy should be to make and keep life human, to sustain a people-sized society.

They propose that this can be accomplished by utilizing society's mediating structures to empower people. Mediating structures are "those institutions which stand between the individual in his private life and the large institutions of public life." (p. 2) Examples are neighborhood, family, church and voluntary associations. "(I)f these institutions could be more imaginatively recognized in public policy individuals would be more "at home" in society, and the political order would be more "meaningful." (p. 3) Thus more services could be "provided" without the state being the provider.

Berger and Neuhaus put forward three propositions: that mediating structures are the value-generating and value-maintaining structures in society, and they are essential for a vital democratic society; that as a minimum public policy should protect and foster mediating structures, and not harm their stability or threaten their existence; and that whenever possible, public policy should utilize mediating structures for the realization of social purposes, with the goal of expanding government services without producing government oppressiveness. This is to be distinguished from decentralization, which "is limited to what can be done <u>within</u> governmental structures." (p. 7) The mediating structures, as the principle expressions of the real values and real needs of people in our society, stand <u>between</u> government and the individual, and by resisting the encroachment of megastructures, can reduce the sense of powerlessness experienced by many in our society.

The crucial importance of community organization and strength may be particularly relevant to the many problems that are lumped together as "mental health problems", including anxiety and neurosis, drug and alcohol abuse, developmental problems in children, domestic violence and child abuse, to related problems such as teen pregnancy, and to a whole host of physical health problems whose causes can be traced in part to "stress".

According to Albee (1982) the crucial factors underlying many of these problems are powerlessness, poor social competence, low self-esteem and lack of support networks. As a result, stresses such as poverty, meaningless work, unemployment, racism and sexism cannot be adequately handled, and problems result. Obviously, a stronger and more organized community may help prevent many of these problems by empowering individuals and the community, reducing stress, enhancing social competence and self-esteem and providing support systems and networks.

The adoption of the health action model leads to a health action strategy which requires us to:

- identify causes of illness in a community in a way which is understandable and meaningful to community individuals
- trace the causal elements of these health problems to social or environmental bases, if appropriate
- develop strategies for intervention which require community action for prevention.

The process through which health action actually occurs has been described by Nix (1977). The steps involved in what he calls "Community Involvement in the Study-Planning-Action Process" are as follows:

1. recognize and describe the need or problem in the community;
2. determine relevant organizations, leaders and factions who should be consulted on the problem or need;
3. initiate the process and legitimize the need by gaining support of key leaders, etc.;

4. diffuse the proposed program to the general public;
5. organize the community to study, plan and act - if need be, create an organization;
6. conduct the study, formulate a plan and recommendations for action;
7. implement the plan;
8. evaluate the program.

Such an approach, however, may not be suitable for all communities or all health problems. Based on their experience in applying the health action model in different communities, McKnight and his colleagues propose five basic conditions that must exist in a community to assure the potential success of a health action program: (Coonley-Hoganson, 1981)

1. The health status of a community must be linked to a relatively poor environment most often associated with low-income impoverished minority people.
2. The victims of the identified health problems must have had little individual control over their predicament. The onset of the problem preferably should be sudden and not a consequence of life-long habits.
3. The problems that can be solved through a Health Action strategy are those in which the primary cause has a social/community context.
4. The problems should have non-technical solutions which require wide community participation to develop and implement. Technical experts can only be used in an advisory role.
5. Most important, there must be an interested constituency within the community to initiate, develop, gather grassroot support and implement the Health Action Program. Preferably, the identified constituency should value the long-range need for collective action to solve local problems in many areas of social change, not necessarily only in the health arena. This must be accomplished through existing local organizations, not through the creation of an institution or agency, for the sole purpose of health promotion which receives funds from a central source outside the community.

While we recognize these criteria, it is our belief that the community development process, suitably adapted, can be used in stable, safe middle class areas to improve the health of the community. While the health action strategy is clearly more suited to low-income groups, the study-planning-action process may be better suited to more middle class settings.

Also, while we clearly have a bias towards health issues, we must be prepared and willing to work with the community on issues of importance to the community. We have to strike a fine balance between initiating action on the one hand and taking over the community on the other. It is not enough to be decentralized, we must learn to utilize (and yet not take over) the mediating structures. The key is community action, not Health Department action.

2. Definitions of Community Development, Organization and Support

In addition to community development, which is the overall process, two terms are used extensively throughout this report, and it is useful to clarify here the way in which we use these terms.

Community development is a process which involves reaching out into the community, identifying key groups and leaders, working with them on problems of mutual concern, helping to empower the community and thus to strengthen its own inherent organization and its support systems, and to take the initiative in coping with its own problems.

Community organization is an outcome of community development and is an indicator of the inherent strength of the community. The more organized a community is, the stronger it is.

Community support referes to the support systems and networks within a community which provide care and support to those members of a community in need of care and support, or simply in need of human contact.

In the context of this report, community support may also refer to support for the goals and activities of the N.H.A.

3. Community Development in the Northern Health Area

A set of four prevention priorities for the N.H.A. have been developed, based upon the N.H.A. Program Priorities Report (1982):

- Smoking prevention
- Stress and suicide
- Injury control
- Occupational Health & Safety

These problems are amenable to a community development approach. In addition, three groups with particularly pressing health and social needs have been identified; giving as three community support priorities:

- the elderly, particularly in North Toronto
- ethnic communities, particularly in Hillcrest
- ex-psychiatric patients

Finally, three targets and thus three strategies for community development were identified, namely:

- the schools, and school health education;
- the workplace, and workplace health programs;
- the general community, and development of community support systems and networks

It has been decided that four N.H.A. prevention work groups will be established to deal with some of these problems. Under the N.H.A. Disease Prevention Committee, a Work Group on Smoking and a Work Group on Stress and Suicide will be responsible for developing suitable new programs, and will include community members and groups in the process. Under the N.H.A. Health Protection Committee, a Work Group on Injury Control and a Work Group on Occupational Health and Safety will have similar responsibilities.

The Community Health Officers will act as community development consultants and facilitators to these four Work Groups, but in addition will have specific responsibility for developing community care and support systems for the elderly (especially in North Toronto), ethnic communities (especially in Hillcrest), and for ex-psychiatric patients. Both the former and the latter issues will receive additional support from the N.H.A. Community Advisory Board (CAB), which is establishing a Task Force on Seniors and a Task Force on Ex-Psychiatric Patients.

It should not be forgotten that community development is not an activity confined to particular issues or particular staff members. Issues where we are already actively involved in community development include family planning, Healthiest Babies Possible and mental health services. But all staff, as our prime contact with the community, need to be alert to the possibilities of community development, and actively involved in the process.

4. Provisional strategies and tactics to implement community development

In the pages that follow, we have used a uniform format to describe in more detail the preliminary strategies and tactics we are proposing for each of the three major targets for community development we have identified, namely the schools, the workplace and the general community. They will be adapted, modified and expanded upon by the four task forces.

First, we have identified broad five-year goals and more specific two-year goals for each target. Next we identify tactics to be utilized in each of five categories, namely:

- information needs
- resource needs
- sources of support (financial, expert, etc.)
- community support (potentially supportive community groups)
- staff educational needs

For each tactic, we have identified the individual, group or committee in the N.H.A. responsible for ensuring the tactic is implemented, and we have identified some potential external sources of help where appropriate. A preliminary task list for each identified individual, group or committee in the N.H.A. is included as Appendix 1. (The task list for the community health workers in effect describes their job for the next few years, and this is expanded to a 1983-4 work plan - Appendix 2).

Finally, the outline of a plan for developing community support for the components of the N.H.A. community development strategy is shown, indicating the major steps we need to take in 1983. (Appendix 3)

5-year goals

For ease of presentation, the five year goals are summarized here.

A. School Health Education

1. Comprehensive school health education to include: smoking, alcohol and drug misuse and abuse; accident prevention; nutrition; fitness; stress; family life and sexuality.

2. Expanded role of PHN's in schools.

B. Workplace Health Programs

1. Workplace health programs available to both management and labour emphasizing: safety; accident prevention; toxic substances; stress; office environment; quality of working life; health and fitness program especially in regard to smoking and alcohol.

C. Community Support Systems

1. Comprehensive support services for the elderly to include: 20 year blue print for meeting future needs; home support; community volunteer networks; sheltered housing; daycare and progressive care; assessment and placement; community health centre for seniors in North Toronto.

2. Provision, improved awareness and use of community resources for and by ethnic communities, including health related services, to include: community mental health; community support networks; culturally appropriate health information services; multicultural community health centre in Hillcrest.

3. Comprehensive community mental health facilities (assessment, intervention, follow-up, maintenance) that are accepted and supported by the local community.

4. Community support for preventive health programs, especially related to school health education, smoking, substance abuse, accident prevention, family life and sexuality, occupational health and environmental health.

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A. SCHOOL HEA' EDUCATION

5-YEAR GOALS

1. Comprehensive school health education to include:
   - smoking, alcohol and drug use, misuse and abuse
   - accident prevention
   - nutrition
   - fitness
   - stress
   - family life and sexuality

2. Expanded role of Public Health Nurses in schools
   i.e. health teaching

2-YEAR GOALS

1. Teaching kits for PHN's
   - smoking
   - substance abuse
   - accident prevention

2. Multi-faceted smoking prevention program in key schools

3. Alcohol education program in key schools

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. data on current school/child behaviour re: smoking, substance abuse	Smoking Work Group with Health Information Committee	Health Information Section, Health Promotion Section
2. services available	Smoking Work Group	School Health Consultant
3. literature searches	Smoking Work Group Injury Control Work Group	School Health Consultant, Health Promotion Section, Disease Prevention Section
4. accident, mortality and morbidity in children	Injury Control Work Group with Health Information Committee	Central Resources, Police
5. inventory of staff education needs	Health Promotion Committee	
b) Resource Needs		
1. reallocation of staff	AMT	DMT
2. materials and supplies	Smoking Work Group, Injury Control Work Group	Central Resources
3. teaching kits	Smoking Work Group, Injury Control Group with Health Promotion Committee	Health Promotion Section
4. displays	Community Health Officers	Central Resources
5. staff training	Health Promotion Committee Smoking Work Group, Injury Control Work Group	Departmental Staff Development Committee
6. media kits giveaways	Community Health Officers, Business Manager	Central Resources

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
c) Sources of Support		
1. Central Resources	Community Health Officers, AMT Smoking Work Group Injury Control Work Group	
2. Ministry of Health		
3. Cancer Society		
4. Lung Association		
5. Heart Foundation		
6. Red Cross		
7. Research Funds		
8. A.R.F.		
9. Foundations - Sick Kids		
d) Community Support		
1. C.A.B.	Smoking Work Group Injury Control Work Group Community Health Officers AMT	School Health Consultant
2. Home and School Associations		
3. Area North Education Council- Health Special Interest Group		
4. School Superintendents and Principals		
5. P.O.I.N.T.		

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
e) Staff Education		
1. Smoking prevention	Health Promotion Committee, Smoking Work Group Injury Control Work Group	School Health Consultant, Health Promotion Section, Disease Prevention Section
2. Teaching techniques		
3. Alcohol education		
4. Inventory of needs		

B. WORK-PLACE HEALTH PROGRAMS

5-YEAR GOAL

1. Work place health programs available to both management and labour emphasizing:

   - safety
   - accident prevention
   - toxic substances
   - stress
   - office environment
   - quality of working life
   - health and fitness programs especially in regards to smoking and alcohol

2-YEAR GOAL

1. Establish link with major management and labour groups in the Area.
2. Establish pilot workplace health programs.
3. Provide pilot non-profit occupational health service to local small workplaces.
4. Provide inspection services for local workplaces.

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. Inventory of workplaces (offices/ industry)	Occupational Health Work Group	Health Protection Section
2. Inventory of programs available		
3. Inventory of existing services		
4. Data on occupational mortality, morbidity	Health Information Committee with Occupational Health Work Group	Health Information Section
b) Resource Needs		
1. Pamphlets	Occupational Health Work Group	OFL, WCB, City, Health & Safety, Ministry of Labour, Environment
2. Teaching kits	Health Promotion Committee	
3. Occupational health education programs		
4. New staff	AMT	
5. Reallocation of staff/staff training	AMT	
c) Sources of Support		
1. Central Resources	Community Health Officers,	Health Protection Section
2. Ministry of Labour	AMT	
3. Workmen's Compensation Board	Occupational Health Work Group	
4. Chambers of Commerce		
5. Ontario Federation of Labour		
6. Metro Labour Council		
d) Community Support		
1. Local unions	Occupational Health Work Group	
2. Local management	Community Health Officers	
3. Local Business groups	AMT	
4. C.A.B.		

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
e) Staff Education		
1. Toxic Substances 2. Occupational health & safety 3. Network development 4. Industrial relations 5. Change process	Health Promotion Committee, Health & Safety Committee Occupational Health Work Group	Health Protection Section Departmental Staff Development Committee, City, Health and Safety, Departmental Health & Safety

C. COMMUNITY SUPPORT SYSTEMS

5-YEAR GOALS

1. Elderly

Comprehensive support services for the elderly to include:
- 20-year blue print for meeting future needs
- home support
- community volunteer networks
- sheltered housing
- daycare and progressive care
- assessment and placement
- community health centre for seniors in North Toronto

2. Ethnic Communities

Provision, improved awareness and use of community resources for and by ethnic community, including health related services to include:
- community mental health
- community support networks
- culturally appropriate health information services
- multicultural community health centre in Hillcrest

3. Ex-psychiatric patients

Comprehensive community mental-health facilities and services (assessment, intervention, follow-up, maintenance) that are accepted and supported by the local community.

4. Community Support for N.H.A. Activities

Community support for preventive health programs, especially related to:
- school health education
- smoking
- substance abuse
- accident prevention
- family life and sexuality
- occupational health
- environmental health

2-YEAR GOALS

1. Elderly

Establishment of "Senior Link" type program in North Toronto to include:
- interagency co-ordinating committee
- community volunteer co-ordinator
- chronic home care
- pilot home support program
- preliminary outline of services needs and plans to meet them
- pilot day care

2. Ethnic Communities

Establishment of multicultural community support network emphasizing mental health
- develop health related programs for MTV, CHIN and other ethnic media

3. Ex-Psychiatric Patients

Decreased resistance to group homes etc.and establishment of 1 or 2 new community facilities for those with mental health problems.

4. Community Support for N.H.A. Activities

Establishment of health special interest groups in Area Education Councils
- regular public displays on priority health issues
- regular medial coverage of preventive health issues
- community support for tough regulatory and legislative action against smoking, alcohol abuse, and drunk driving, and for occupational and environmental health protection.
- an active Community Advisory Board

1. ELDERLY

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. Needs inventory	Community Health Officer	Adult and Rehabilitation Consultant, Community Information Centre, POINT HINTS, West Metro Senior Citizens
b) Resource Needs		
1. Information pamphlets	Health Promotion Committee, Community Health Officers	Adult Rehabilitation Consultant, Health Promotion Section
2. Community volunteer co-ordinator or possible reallocation of staff	AMT	DMT
3. Seed money for projects	Community Health Officers, AMT	DMT
c) Sources of Support		
1. COMSOC 2. Wintario 3. City of Toronto 4. Foundations 5. Lions 6. Metro Social Services	Community Health Officers, AMT	
d) Community Support		
1. C.A.B. 2. Task Force on the Elderly 3. P.O.I.N.T. 4. S.A.I.N.T.S. 5. H.I.N.T.S. 6. West Metro Senior Citizens 7. Care-Ring 8. Churches 9. Jewish Community Services	Planning: Community Health Officers, AMT, (PCS, PHS) Action: NHA staff based on involvement in agencies	

TACTICS (continued...)	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
c. Community Support (cont'd.)		
10. Y.M.C.A.		
11. Meals on Wheels		
12. Home Care		
13. Sunnybrook Hospital		
14. Planning & Development Area Planners		
e) Staff Education		
1. Community organization/development	Health Promotion Committee, Community Health Officers	Departmental Staff Development Committee

2. ETHNIC COMMUNITIES

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. Needs inventory	Community Health Officers	
2. Resource inventory		
3. Inventory of staff education needs	Health Promotion Committee	
4. Data on effective communication techniques for N.H.A. multicultural communities	Health Promotion	Multicultural Committee, Health Promotion Section
5. Continuous monitoring of where they are	Community Health Officers	Health Information Section Churches
6. Data on health status	Health Information Committee	Health Information Section
b) Resource Needs		
1. Multilingual pamphlets	Community Health Officers, Health Promotion Committee	Health Promotion Section, City Clerks, MTV
2. Multilingual radio/TV materials		
3. Multilingual staff (review City recruitment policy)	AMT	DMT
4. Community health aides	AMT	DMT, Immigrant Women's Centre
5. Multicultural health guide	Community Health Officers, Disease Prevention Committee	Immigrant Women's Centre, individual groups

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
c) Sources of Support		
1. Multicultural Worker 2. CHIN 3. COSTI 4. Churches 5. Ministry of Culture 6. Ministry of Health 7. Immigration-Federal 8. Province	Community Health Officers, AMT	
d) Community Support		
1. Key professionals 2. Politicians 3. Churches 4. Organizations 5. District Health Council	Planning: Community Officers, AMT Action: NHA staff	
e) Staff Education		
1. Based on inventory of needs and resource manual 2. Health acculturation	Health Promotion Committee	Departmental Health Promotion Committee

3. EX-PSYCHIATRIC PATIENTS

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. Group homes, boarding homes inventory	Mental Health Nurse, Inspectors	Disease Prevention Section, Community Resource Consultants, Mental Health Metro
2. Admission/discharge - ex-psychiatric patient censue	Health Information Committee	Community Resource Consultants, DHC
b) Resource Needs		
1. Community mental health workers - 2	AMT	DMT
c) Sources of Support		
1. Ministry of Health 2. City of Toronto 3. C.M.H.A. 4. Foundations 5. Clarke Institute - Community	Community Health Officers, AMT	
d) Community Support		
1. C.A.B. 2. CRC 3. Police 4. Hospitals 5. Local community residents' association 6. Churches 7. Ex-psychiatric Patients' Associations - On Our Own 8. Community Information 9. Adult Rehabilitation 10. District Health Council	Planning: Community Health Officers, AMT	
e) Staff Education		
1. Community organization/development	Health Promotion Committee, Community Health Officers	Departmental Health Promotion Committee

4. COMMUNITY SUP[illegible]T FOR NHA ACTIVITIES

TACTICS	N.H.A. RESPONSIBLE INDIVIDUAL/COMMITTEE	RESOURCES
a) Information Needs		
1. Data on community attitudes, behaviour re: preventive health	Health Information Committee	Health Information Section
2. Inventory of supportive groups 3. Inventory of location for displays etc. 4. sympathetic journalists 5. available resources - films, slides etc.	Community Health Officers	Health Promotion Section
b) Resource Needs		
1. Displays 2. Budget for photocopying 3. Budget for flyers 4. Media Kits 5. Films	Community Health Officers, AMT, Health Promotion Committee	Health Promotion Section
c) Sources of Support		
1. Central Resources 2. Ministry of Health, or any other appropriate Ministry 3. Industry and Labour 4. Hospitals 5. Voluntary associations	Community Health Officers, AMT	
d) Community Support		
1. Identify and influence key community groups 2. C.A.B.	Planning: Community Health Officers, AMT Action: NHA staff	
e) Staff Education		
1. PR 2. [illegible]munity development	Healt[illegible]romotion Committee, Commun[illegible]ealth Officers	Departmental Staff Development Commit[illegible]

APPENDIX 1.

RESPONSIBLE N.H.A. INDIVIDUALS AND COMMITTEES

COMMUNITY HEALTH OFFICERS

I. SCHOOL HEALTH EDUCATION

1. Displays
2. Media kit giveaways (with Business Manager)
3. Secure support from various organizations/foundations/agencies (with AMT and Smoking and Injury Control Work Groups)
4. Plan strategies to garner community support (with AMT & Work Groups)
5. Staff education on community organization/development (with Health Promotion Committee)

II. COMMUNITY SUPPORT SYSTEMS

A. Elderly

1. Inventory of needs
2. Inventory of resources
3. Information pamphlets
4. Seed money for projects (with AMT)
5. Secure support from various organizations/foundations/agencies (with AMT)
6. Plan strategies to garner community support (with AMT)

B. Ethnic

1. Needs inventory
2. Resource inventory
3. Continuous monitoring of where they are
4. Develop multilingual pamphlets (with Health Promotion Committee)
5. Develop multilingual radio/TV materials (with Health Promotion Committee)
6. Multicultural health guide
7. Secure support from various organizations/foundations/agencies (with AMT)
8. Plan strategies to garner community support (with AMT)

C. Ex-Psychiatric Patients

1. Secure support from various organizations/foundations/agencies (with AMT)
2. Plan strategies to garner community support (with AMT)
3. Staff education on community organization/development (with Health Promotion Committee)

D. Community Support

1. Inventory of supportive groups
2. Inventory of location for displays etc.
3. Inventory of sympathetic journalists
4. Inventory of available resources 0 films, slides etc.
5. Displays
6. Budget for flyers (with AMT)
7. Media kits (with Health Promotion Committee)
8. Films
9. Secure support from various organizations/foundations/agencies (with AMT)
10. Plan strategies to garner community support (with AMT)
11. Staff education on PR, community development, change process (with Health Promotion Committee)

III. WORK PLACE HEALTH PROGRAMS

1. Secure support from various organizations/foundations/agencies (with AMT, Occupational Health Work Group)
2. Plan strategies to garner community support (with AMT and Occupational Health Work Group)

AREA MANAGEMENT TEAM

I. SCHOOL HEALTH EDUCATION

1. Reallocation of staff
2. Secure support from various organizations/foundations/agencies (with CHO's, Smoking and Injury Control Work Groups)
3. Plan strategies to garner community support (with CHO's, Smoking and Injury Control Work Groups)

II. COMMUNITY SUPPORT SYSTEMS

A. Elderly

1. Community volunteer co-ordinator or possible reallocation of staff
2. Seen money for projects (with CHO's)
3. Secure support from various organizations/foundations/agencies (with CHO's)
4. Plan strategies to garner community support (with CHO's)

B. Ethnic

1. Review City recruitment policy re: hiring multilingual staff
2. Community health guides
3. Secure support from various organizations/foundations/agencies (with CHO's)
4. Plan strategies to garner community support (with CHO's)

C. Ex-Psychiatric Patients

1. Community mental health workers (2)
2. Secure support from various organizations/foundations (with CHO's)
3. Plan strategies to garner community support (with CHO's)

D. Community Support

1. Budget for photocopying
2. Budget for flyers
3. Secure support from various organizations/foundations/agencies (with CHO's)
4. Plan strategies to garner community support (with CHO's)

III. WORK PLACE EDUCATION

1. New staff
2. Reallocation of staff
3. Secure support from various organizations/agencies (with CHO's, Occupational Health Work Group)
4. Plan strategies to garner community support (with CHO's, Occupational Health Work Group)

HEALTH INFORMATION COMMITTEE

I. SCHOOL HEALTH EDUCATION

1. Data on current school/child behaviour re: smoking substance abuse (with Smoking Work Group)
2. Data on accident, mortality and morbidity in children (with Injury Control Work Group)

II. COMMUNITY SUPPORT SYSTEMS

A. Elderly

B. Ethnic

1. Data on health status of the ethnic population

C. Ex-Psychiatric Patients

1. Admission/discharge - ex-psychiatric patient census

D. Community Support

1. Data on community attitudes, behaviour re: preventive health

III. WORK PLACE EDUCATION

1. Data on occupational mortality, morbidity (with Occupational Health Work Group)

HEALTH PROMOTION COMMITTEE

I. SCHOOL HEALTH EDUCATION

1. Inventory of staff education needs
2. Teaching Kits (with Smoking and Injury Control Work Groups)
3. Staff training (with Smoking and Injury Control Work Group)
   - smoking prevention
   - teaching techniques
   - alcohol education

II. COMMUNITY SUPPORT SYSTEMS

A. Elderly

1. Information pamphlets
2. Staff education on community organization/development (with CHO's)

B. Ethnic

1. Inventory of staff education needs
2. Data on effective communication techniques for NHA multicultural communities
3. Develop multilingual pamphlets (with CHO's)
4. Develop multilingual radio/TV materials (with CHO's)
5. Staff education based on inventory of needs and training on health acculturation

C. Ex-Psychiatric Patients

1. Staff education on community organization/development (with CHO's)

D. Community Support

1. Media kits (with CHO's)
2. Staff education on PR, community development, change process (with CHO's)

III. WORK PLACE EDUCATION

1. Pamphlets (with Occupational Health Work Group)
2. Teaching kits (with Occupational Health Work Group)
3. Staff education on: (with Health Protection Committee & Health & Safety Committee)
   - toxic substances
   - occupational health & safety
   - network development
   - industrial relations
   - change process

DISEASE PREVENTION COMMITTEE

A. SCHOOL HEALTH EDUCATION

B. COMMUNITY SUPPORT SYSTEMS

2. Ethnic
   - multicultural health guide (with CHO's)

HEALTH & SAFETY COMMITTEE

I. WORK-PLACE EDUCATION

1. Occupational Health Education Programs (with Occupational Health Work Group, Health Protection Committee)

2. Staff education (with Occupational Health Work Group, Health Promotion Committee)
   - toxic substances
   - occupational health & safety
   - network development
   - industrial relations
   - change process

SMOKING WORK GROUP

SCHOOL HEALTH EDUCATION

1. Data on current school/child behaviour re: smoking (with Information Committee)
2. Inventory of services available
3. Literature searches
4. Materials and supplies
5. Teaching kits (with Health Promotion Committee)
6. Staff training (with Health Promotion Committee)
7. Secure support (with CHO's, AMT)
8. Staff education (with Health Promotion Committee)

INJURY CONTROL WORK GROUP

SCHOOL HEALTH EDUCATION

1. Literature searches
2. Accident mortality and morbidity in children (with information committee)
3. Materials and supplies
4. Teaching kits (with Health Promotion Committee)
5. Staff training (with Health Promotion Committee)
6. Secure support (with CHO's, AMT)
7. Staff education (with Health Promotion Committee)

OCCUPATIONAL HEALTH WORK GROUP

WORKPLACE HEALTH PROGRAMS

1. Inventory of workplaces
2. Inventory of programs available
3. Inventory of existing services

WORKPLACE HEALTH PROGRAMS (continued...)

4. Data on occupational mortality and morbidity (with Health Information Committee)
5. Pamphlets (with Health Promotion Committee)
6. Teaching kits (with Health Promotion Committee)
7. Secure support (with CHO's, AMT)
8. Staff education (with Health Promotion Committee, Health & Safety Committee)

PUBLIC HEALTH INSPECTORS

I. COMMUNITY SUPPORT SYSTEMS

Ex-Psychiatric Patients

1. Group Homes, boarding homes inventory

MENTAL HEALTH NURSE

I. COMMUNITY SUPPORT SYSTEMS

Ex-Psychiatric Patients

1. Group Homes, boarding homes inventory

APPENDIX 2

N.H.A. COMMUNITY HEALTH OFFICERS WORK PLAN - 1983 - 4

A. SCHOOL HEALTH EDUCATION

All activities in consultation with work groups on smoking and injury control.

Displays

a) coordinate displays on these issues

b) organize display package on these issues

Media kit giveaways

a) Work with Public Relations Coordinator

b) Develop media kit giveaways on these subjects

Secure support from various organizations/foundations/ agencies

a) Submit or help existing organizations to submit proposals, research grants to secure funds for pilot school health education programs on these issues

Plan strategies to garner community support (see 1983 targets for community support)

Staff Education on community organization/development

a) Organize staff education on community organization/development

B. WORKPLACE EDUCATION

Secure support from various organizations/foundations/ agencies

a) Submit or help other agencies to submit proposals, research grants to secure funds and/or support for pilot work place health programs

Plan strategies to garner community support (see 1983 targets for community support)

C. COMMUNITY SUPPORT SYSTEMS

Elderly

1. Inventory of Needs
   a) Consult with Adult Rehab. Consultant
   b) Meet with coordinator of Services for Elderly and Disabled (Martha Bobrowski)
   c) Meet with City Task Force on the Edlerly
   d) Meet with agencies working with the Elderly in the N.H.A.
   e) Meet with the Elderly
   f) Report on needs assessment

2. Inventory of Resources
   a) Consult with Adult Rehab. Consultant
   b) Meet with Coordinator of Services for Elderly and Disabled (Martha Bobrowski)
   c) Meet with City Task Force on the Elderly
   d) Meet with agencies working with the Elderly in the N.H.A.
   e) Meet with the Elderly
   f) Report on resource assessment

3. Information Pamphlets
   a) Develop information pamphlets for the Elderly

4. Seed Money for Projects
   a) Submit proposals, research grants to secure seed money for projects depending on needs and resource inventories

5. Secure support from various organizations/ foundations/agencies
   a) Submit or help other agencies to submit proposals, research grants to secure support for projects for the Elderly

6. Plan strategies to garner community support (see 1983 targets for community support)

Ethnic Communities

1. Needs Inventory
   a) Meet with ethnic communities in N.H.A.
   b) Meet with agencies working with the ethnic communities in N.H.A.
   c) Report on needs assessment
2. Resource Inventory
   a) Meet with ethnic communities in N.H.A.
   b) Meet with agencies working with the ethnic communities in the N.H.A.
   c) Report on resource assessment
3. Continuous monitoring of where they are
   a) Update demographic data on ethnic communities every year
4. Develop multilingual pamphlet
   a) Based on needs and resource assessment, develop appropriate multilingual pamphlet
5. Develop multilingual radio/T.V. materials
   a) Meet with ethnic media re: needs resource assessment
   b) Develop appropriate multilingual radio/T.V. materials
6. Multicultural health guide
   a) Meet with ethnic communities, agencies working with ethnic communities re: needs and resource assessment report
   b) Develop a multicultural health working group in N.H.A.
      - one goal of which is to develop a multicultural health guide

7. Secure support from various organizations/foundations/ agencies
   a) Submit or help other agencies to submit proposals, research grants to secure funds and/or support to develop a multicultural community support network

8. Plan strategies to garner community support (see 1983 targets for community support)

Ex-Psychiatric Patients

1. Secure support from various organizations/foundations/ agencies
   a) Submit or help other agencies to submit proposals, research grants to secure funds and (or support to establish community facilities for those with mental health problems

2. Plan strategies to garner community support (see 1983 targets for community support)

3. Staff education on community organization/development
   a) Organize staff education on community organization/ development

APPENDIX 3

1983 TARGETS FOR COMMUNITY SUPPORT FOR N.H.A. COMMUNITY DEVELOPMENT STRATEGY

SCHOOL HEALTH EDUCATION

A. C.A.B.

1. to adopt school health education as a priority.
2. to strike a school health task force.

B. Home and School Associations

1. staff to be members of Home & School Associations.
2. school health nurses to attend Home & School Association.
3. presentation to all Home and School re: smoking prevention and other school health education programs.

C. Area North Education Council

1. staff person on executive.
2. establish a Health Special Interest Group.

D. Area West Education Council

1. staff person on executive.
2. establish a Health Special Interest Group

E. P.O.I.N.T.

1. support comprehensive school health education.
2. staff person to be a member of the Health Committee.
3. staff person on Board of Directors.

F. School Superintendent and Principals

1. commitment to comprehensive school health education.
2. co-operate in developing and implementing school health education

COMMUNITY SUPPORT SYSTEMS - ELDERLY

A. C.A.B.

1. recognize elderly as a priority.
2. establish a task force.

B. City Task Force on Elderly

1. staff person to be a member.

C. POINT, SAINTS, HINTS, West Metro Senior Citizens, Politicians, etc.

1. bring groups in a meeting to discuss boundaries.
2. establish a network for the elderly.
3. establish a senior working group in Wards 3 and 5.
4. contact key people e.g. Ministers, Politicians to meet re: services to seniors.

D. Health Care Providers (Sunnybrook Hospital, etc.)

1. support their provision of outreach and ambulatory care.
2. provide community experience for family practice residents.
3. develop close working relationship with family physicians.

COMMUNITY SUPPORT SYSTEMS - EX-PSYCHIATRIC PATIENTS

A. C.A.B.

1. to advocate for better community mental health resources for ex-psychiatric patients.
2. to become involved with existing services for ex-psychiatric patients.

B. Community Resource Consultants (CRC)

1. work with CRC to assess existing services and identify gaps.
2. work with CRC to advocate for new, improved or expanded services.

C. Community Inn, Police, On Our Own, etc.

1. work with to advocate for new, improved or expanded services.

COMMUNITY SUPPORT SYSTEMS - ETHNIC COMMUNITIES

A. C.A.B.

1. have representation of key ethnic communities on C.A.B.

B. Key Professionals

1. join or develop a multicultural health network in N.H.A.

C. Politicians/Churches/Organizations

1. work with to develop a multicultural community support network.

D. District Health Council

1. recognize the health problems of ethnic communities as a priority.
2. start a multicultural health subcommittee.

WORK PLACE HEALTH PROGRAMS

A. Local Unions, Local Management, Local Business Groups

1. to identify and establish link with existing local unions, management and business groups.
2. to work with local unions, management and business groups to initiate pilot work place health programs.

POOR

QUALITY

ORIGINAL